§405.1804 Matters not subject to administrative and judicial review under prospective payment.

Neither administrative nor judicial review is available for controversies about the following matters:

(a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates.

(b) The establishment of—

(1) Diagnosis related groups (DRGs);

(2) The methodology for the classification of inpatient discharges within the DRGs; or

(3) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

[49 FR 322, Jan. 1, 1984]

§405.1805 Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary to be a related organization of the provider under §413.17 of this chapter.

[48 FR 39835, Sept. 1, 1983, as amended at 51 FR 34793, Sept. 30, 1986]

§405.1807 Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with §405.1811 and an intermediary hearing decision rendered in accordance with §405.1831; or

(b) The intermediary determination is revised in accordance with §405.1885; or

(c) A Board hearing is requested in accordance with §405.1835 and a hearing decision rendered pursuant thereto.

§405.1809 Intermediary hearing procedures.

(a) *Hearings.* Each intermediary must establish and maintain written procedures for intermediary hearings, in accordance with the regulations in this subpart, for resolving issues that may arise between the intermediary and a provider concerning the amount of reasonable cost reimbursement, or prospective payment due the provider (except as provided in §405.1804) under the Medicare program. The procedures must provide for a hearing on the intermediary determination contained in the notice of program reimbursement (§405.1803), if the provider files a timely request for a hearing.

(b) *Amount in controversy.* In order for an intermediary to grant a hearing, the following dates and amounts in controversy apply:

(1) For cost reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy must be at least $1000.

(2) For cost reporting periods ending on or after June 30, 1973, the amount of program reimbursement in controversy must be at least $1000 but less than $10,000.

[48 FR 39835, Sept. 1, 1983, as amended at 49 FR 323, Jan. 1, 1984]

§405.1811 Right to intermediary hearing; contents of, and adding issues to, hearing request.

(a) *Criteria.* A provider (but no other individual, entity, or party) has a right to an intermediary hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period, but only if—

(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—

(i) Including a claim for a specific item(s) on its cost report for a period if the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing a specific item(s) by following the applicable procedures for filing a cost report under protest, if the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)),

(2) The amount in controversy (as determined in accordance with §405.1839 of this subpart) is at least $1,000 but less than $10,000; and

(3) Unless the provider qualifies for a good cause extension under § 405.1813 of this subpart, the date of receipt by the intermediary of the provider's hearing request must be—

(i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; or

(ii) When the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12-month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped ''Received'' unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

(b) *Contents of request for an intermediary hearing.* The provider's request for an intermediary hearing must be submitted in writing to the intermediary, and the request must include the elements described in paragraphs (b)(1) through (b)(3) of this section. If the provider submits a hearing request that does not meet the requirements of (b)(1), (b)(2), or (b)(3) of this section, the intermediary hearing officer may dismiss with prejudice the appeal, or take any other remedial action he or she considers appropriate.

(1) A demonstration that the provider satisfies the requirements for an intermediary hearing as specified in paragraph (a) of this section, including a specific identification of the intermediary or Secretary determination under appeal.

(2) An explanation, for each specific item at issue (as described in paragraph (a)(1) of this section), of the provider's dissatisfaction with the intermediary or Secretary determination under appeal, including an account of—

(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it allegedly does not have access to underlying information concerning the calculation of its payment); and

(ii) How and why the provider believes Medicare payment should be determined differently for each disputed item.

(iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for any item.

(3) A copy of the intermediary or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

(c) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the intermediary hearing officer, only if the following requirements are met:

(1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.

(2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.

(3) The intermediary hearing officer receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.

[73 FR 30244, May 23, 2008]

§ 405.1813 Good cause extension of time limit for requesting an intermediary hearing.

(a) A request for an intermediary hearing that is received by the intermediary after the applicable 180-day time limit prescribed in § 405.1811(a)(3) of this subpart must be dismissed by